EMPLOYEE'S CHOICE
VOLUNTARY GROUP BENEFIT PLANS
A product of
SOUTHERN NATIONAL LIFE INSURANCE COMPANY, INC.,
referred to as the Company

P.O. Box 98044
Baton Rouge, LA 70898-9044
Phone: 1-800-376-7734
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EMAIL: SNL_ECEnrollment@bcbsla.com

VOLUNTARY DENTAL GROUP EMPLOYEE ENROLLMENT FORM AND CHANGE of STATUS FORM

Total Monthly Premium $_____

TO BE COMPLETED BY EMPLOYER

Enrollment Type:	□ New	□ Late	□ Rehire	□ Open
Change:	□ Name	□ Address	□ Location	□ Class

□ COBRA	Type of Qualifying Event	Date of Qualifying Event

Name of Employer (Use name from billing or group Enrollment Form)	Group No.	Location	Class

TO BE COMPLETED BY EMPLOYEE

Last Name	First Name	MI	□ Male □ Female	□ Married □ Single

Mailing Address	City	State	Zip Code

Social Security Number	Full-Time Employment Date (MM/DD/YYYY)	Rehire Date (MM/DD/YYYY)

Birthdate (MM/DD/YYYY)	Phone Number	Occupation/Position

Hours worked per week	Deduction Frequency □ Weekly □ Bi-Weekly □ Monthly □ Semi-Monthly Other:_____

SECTION A—COVERAGE ELECTION

□ Employee
□ Employee + Spouse
□ Employee + Child
□ Employee + Family
□ Dual Option 1
□ Dual Option 2 - Elect one option if your employer is providing a Dual Option Plan.
□ **I Decline** Reason _____

SECTION B – DEPENDENT INFORMATION

	Last	First	MI	Birthdate	Gender	Do any of your dependents have any other dental coverage?	If yes, Name of Carrier
Spouse Name □ Add □ Change □ Drop						□ Yes □ No	
Children	□ Add □ Change □ Drop					□ Yes □ No	
	□ Add □ Change □ Drop					□ Yes □ No	
	□ Add □ Change □ Drop					□ Yes □ No	
	□ Add □ Change □ Drop					□ Yes □ No	

- **I UNDERSTAND & ACKNOWLEDGE** that I have received a copy of the Company's Notice of Information of Privacy Practices.
- A certificate of coverage will be produced by the Company and distributed through my employer.
- I certify that under penalties of perjury that the Social Security Number shown on page 1 of this Enrollment Form is correct to the best of my knowledge and I am not subject to backup withholding.
- In absence of fraud, my answers in this Enrollment Form shall be deemed representations and not warranties. If any data have been misstated, the correct data will be used to determine if insurance is in force. If insurance is in force the premium and/or benefits will be adjusted according to the facts. No agent has the authority to change any part of this Enrollment Form.
- **FRAUD STATEMENT**: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an Enrollment Form or Enrollment Form for insurance is guilty of a crime and may be subject to fines and confinement in prison. I understand any material misstatement on this enrollment form may result in a denial of a claim and/or discontinuance of coverage.
- **IF DECLINING COVERAGE, I UNDERSTAND** that I have been given the opportunity to participate in the group insurance plan offered by my employer. I am declining the coverage(s) indicated. I fully understand by this declination, neither I nor my dependents will be entitled to any benefits under the coverage(s) I've marked as declined. If I and/or my dependents desire to participate at a later date, coverage(s) may be limited.

All the information provided on this form is true and correct to the best of my knowledge, information and belief.

Enrollee Signature (Required for Enrollment and Declination of Coverage)	**Date of Signature**
X	